MASSACHUSETTS CAMPAIGN FOR SINGLE PAYER HEALTH CARE

MASS-CARE's Comments on LECG's Final Report

MASS-CARE would like to thank the Legislature, the co-chairs of the Advisory Committee, the Committee staff and LECG for the time and effort they put into developing options for providing universal care for the citizens of the Commonwealth. It is also grateful for this opportunity to submit its comments on this important report.

LECG's report determines that, among the three models it examined, its "hybrid" single-payer model is the most cost effective, although, in MASS-CARE's view, LECG's "hybrid" significantly underestimates the savings a pure single-payer model would achieve. This report should make clear once and for all that consolidated financing through single-payer reform is the cheapest and fairest means to universal coverage. Particularly given this, LECG's failure to provide detailed financing mechanisms for the models considered as required by the Legislature and the Commission's contract with LECG is very disappointing.

LECG's report contains several critical findings.

First, of all the models examined, LECG's "hybrid" single-payer system is the only one that:

- provides universal coverage;
- provides comprehensive benefits, including long-term care, dental and vision;
- consolidates existing financing streams, as required by Section 32 of Chapter 141 of the Acts of 2000; and
- reallocates to patient care any of the 39 percent of the Massachusetts health care dollars currently spent administering our patchwork, multi-payer financing system.

Second, assuming current reimbursement levels, LECG concludes that universal, comprehensive coverage with its "hybrid" single-payer model costs less per insured than providing less generous benefits to fewer people would with the other models. Despite its substantially expanded benefit package, LECG's "hybrid" single-payer proposal costs less than $7,000 per insured. Each of the other two models examined cost more than $7,000 per insured while providing fewer benefits and leaving significant numbers of Massachusetts residents uninsured or underinsured.

Third, and perhaps most important of all, LECG finds that our current health care financing system is unsustainable and recommends that Massachusetts pursue dramatic restructuring to obtain efficiencies in financing, administration and health care delivery. Without such changes, health care costs will become prohibitive or, in order to contain costs, we will have to sacrifice access, quality and/or our position as one of the world's leading health centers.

LECG's report basically confirms the broad findings of previous studies of Massachusetts health care system reforms, particularly the relative cost efficiency of single-payer reform compared to incremental reform. The report fails, however, in several important respects to provide the stakeholders in the health care system and the Legislature with a "road map" to universal health care coverage with consolidated financing.

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- LECG fails to analyze a true single-payer system and all the savings associated with this type of reform;
- LECG's "hybrid" single-payer model substantially overestimates the costs of a true single-payer system;
- LECG underestimates the systemic costs of the other two models by excluding the costs of the remaining uninsured and underinsured;
- LECG fails to provide detailed financing mechanisms for any of the models examined (including the baseline model) and specific impacts on individuals of different income levels and on employers of different sizes as required by contract; and
- LECG fails to discuss what Massachusetts should expect if we just continue with "business as usual."

The purpose of single-payer reform is to eliminate multiple payers, their administrative costs and the administrative costs they impose on providers and facilities. LECG estimates that over $16 billion, about 39 percent, of our health care spending goes not to providing health care but to administering our patchwork, multi-payer health care system –16 percent of our health care spending, over $6.6 billion, goes to insurer administration alone. Yet LECG's "hybrid" single-payer model:

- achieves less than $2 billion in administrative savings in the entire health care system;
- apparently finds no net savings in insurer administration; and
- includes no savings associated with timely, coordinated care in appropriate settings.

As a result, LECG concludes that a single-payer system providing comprehensive, universal coverage will cost $2.6 billion more than we are currently spending. This result is not supported by other single-payer studies of Massachusetts, other states and the United States performed by the Lewin Group, the Rand Corporation, Mathematica Policy Research, Health Reform Program/Solutions for Progress, the General Accounting Office and the Office of Management and Budget, among others, which consistently demonstrate that the expansion of coverage and benefits associated with single-payer reform can be fully funded through savings from consolidated financing, changes in resource utilization patterns, and timely, coordinated care.

LECG's apparent conclusion that moving from a multi-payer to a single-payer system produces virtually no insurer administrative savings is both counterintuitive and inconsistent with the findings of the above studies. It is also inconsistent with Medicare's administrative costs of somewhere between 3–5 percent at the insurer level. LECG's "cost point" methodology for estimating administrative savings makes it impossible to determine the actual role of private insurers after reform, but given the very limited savings realized, MASS-CARE assumes that they have a far more substantial role than is consistent with a pure single-payer system. MASS-CARE has made several suggestions throughout the Advisory Committee process that it believes would significantly reduce administrative costs and is disappointed that none of them have been modeled, particularly given the fact that LECG has modeled alternate scenarios for the other models.

LECG assumes that single-payer reforms will produce:

- only a 5.17 percent administrative savings system wide for acute care;
- no savings associated with patient care paid for through worker's compensation and auto insurance; and
- no savings for dental or long-term care.

MASS-CARE believes these assumptions are conservative, based on LECG's own analysis and the analyses of others. Despite the fact that LECG's analysis produces a range of system wide

administrative savings of between 5.17 percent and 9.17 percent in the report's text LECG relies exclusively on the lowest end of the range. A 9.17 percent savings, even with its assumption of no insurer savings, saves an additional $1.5 billion and pays for almost 60 percent of the cost of universal and comprehensive coverage. Applying those administrative savings to patient care paid for by workers compensation and auto insurance and adding reasonable clinical savings pays for more than 80 percent of the expanded benefits and coverage provided by single-payer reform. LECG offers no explanation for using the lowest value of the range it identifies and MASS-CARE believes, based on other studies, that the high end of LECG's savings range significantly underestimates the savings that could be expected from a true single-payer system. MASS-CARE does not expect all administrative costs to go away, but realistic assumptions, on the order of 10–12 percent, of administrative and clinical savings should fund expanded coverage and benefits in a single-payer system.

LECG's cost estimates for Models I and II, specifically exclude the health care costs of the uninsured and underinsured. Both models leave significant numbers of Massachusetts uninsured or underinsured and Model II may actually increase the number of underinsured Massachusetts residents. MASS-CARE lacks the resources to accurately estimate their out-of-pocket costs, but LECG's failure to include them makes those Models appear significantly less costly than they in fact are.

LECG failed to provide decision makers with critical information about options for financing the various Models it examined. It proposes new payroll taxes on employers and employees and a mix of income and other taxes to make up the difference. In no case does LECG provide information on concrete impacts on individual taxpayers of different incomes or on employers of different sizes. The LECG Contract Supplement dated December 14, 2001 specifically required this information. Since LECG's report for the most part duplicates the findings of previous reports in terms of the relative cost efficiencies of single-payer versus incremental reforms, the absence of concrete financing options greatly diminishes its value. LECG's failure should, however, create a clear agenda for future action by the Legislature and stakeholders in our health care system.

Finally, LECG makes a passing reference to the need in Massachusetts to pursue fundamental reforms in order to preserve our health care system. LECG's failure to expand on this point is disappointing. There is a broad consensus that our health care system is in crisis. Costs are rising. Coverage and benefits are shrinking. The numbers of uninsured and underinsured are rising. Reimbursement rates are dropping. We have had decades of market-based, managed care reforms that seem unable to contain costs. As rational economic actors, all the stakeholders are trying to find ways to contain their costs and shift them to someone else by raising premiums, cutting coverage, or deferring needed care. This cost shifting shell game produces no savings and in the end and may actually increase costs. One example of this shell game is the Commonwealth's plan to cut 50,000 MassHealth beneficiaries next April – a plan that produces state budget savings in this fiscal year, but shifts costs to private employers, insurers and hospitals through an estimated $150 million increase in uncompensated care pool costs in the next fiscal year.

LECG's failure to put the full range of choices faced by stakeholders and their associated costs in context makes it appear easier to do nothing to reform an unsustainable health care system than to take actions that will strengthen it.

LECG's failure must not become ours.